CLIENT INFORMATION Date _______________

Intake Information for Adult

Name ___________________________________DOB______________________

Address ____Apt. _______

City _________________________________ State _____ Zip ____________

Phone (cell) ________________ (hm) ________________ (wk) ________________

Email ____

Employer/School _______________________Occupation/Studying _________________

Emergency contact information ____

Phone _______________ Email ____

Referral Information

How did you hear about my services? Please mark the option that applies:

___ Internet
___ Referral from a friend or family member
___ School staff
___ Another mental health professional
___ Other, please specify:
____

If someone referred you to me, may I thank this person for the referral? Yes ___ No ___

Family Information

Relationship Status: Single ___ Married ___ Partnered ___ Divorced ___ Widow/Widower ___

This is my: 1st ___ 2nd ___ 3rd ___ 4th ___ marriage or partnership

Number of children and their ages: ____

____

Were/are your parents: Divorced ___ Never Married ___ Still Married ___ Widowed ___

Where are you in the birth order of siblings in your family? ______________________________

Is there a family history of:

Depression Suicide Attempts Anxiety Eating Disorders Mental Illness

Violence Sexual Abuse Emotional Abuse Alcoholism/Drug Addiction

Chronic Illness Other, please specify ____

Please explain any chronic illness

____

____

Please provide the following information for your family.

	First Name	Current Age or Age at Death	Illness or Cause of Death	Occupation
Parent/Guardian				
Parent/Guardian				
Step-Parents				
Grandparents				
Uncles/Aunts				
Brothers				
Sisters				

Social/Relationship Information

Please indicate any of the following that you have experienced.

Death of:	Your age :
Mother	
Father	
Child	
Sibling	
Other significant person in your life	

Other events:	Your age:
Desertion of Mother	
Desertion of Father	
Divorce of Parents	
Sexual / Emotional / Physical Abuse	
Violence in the Family	
Mental Illness of Family Member	

How do you get along with your present spouse or partner? ______________________________________

____

How do you get along with your children? ____

____

How do (or did) you get along with your family of origin?

Mother ____

Father ____

Siblings ____

Please list your significant friends and indicate how long those friendships have been in place.

First Name	How Long	How often do you see this friend?

What do you consider your strengths? ____

____

____

What are your interests (hobbies, etc.) ____

____

Spiritual Resources

How significant a role does spirituality play in your life?

None _____ Somewhat important _____ Significant _____ Very Significant _____

Religious Orientation or Spiritual Practice ____

____

Employment Information

Current occupation __________________________________ How long at current job? _________

How satisfied are you in your job?

Not Satisfied ___ Somewhat Satisfied ___ Comfortable ___ Very Satisfied ___

Are you satisfied that the income from your job adequately covers your living expenses?

Not Satisfied ___ Somewhat Satisfied ___ Comfortable ___ Very Satisfied ___

Do you have other sources of income? Yes ___ No ___

If yes, please describe ____

Medical Information & History

Primary Physician ____________________________________ Phone __________________

Date of Last Exam _______________________

Major or Chronic Illnesses/Injuries

____

____

Operations

____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have there been recent changes in any of the following areas?

Sleep Dreams/Nightmares Amount of Exercise Eating/Appetite Weight Sexual Desire

Please describe the change:

____

How would you characterize your overall health?

Poor Fair Good Excellent

Do you smoke? Yes ___ No ___ # cigarettes/day ___ Have you smoked in the past? Yes ___ No ___

Age you began smoking and age when you quit (if applicable) _________________________________

Do you consume alcohol? Yes ___ No ___ If so, how much:

Less than 1x/month ___ 1-3x/month ___ 1x/week ___ Several x's/week ___ Every day ___

Check all that apply: ___ Beer ___ Wine ___ Hard Liquor

Do you use any street drugs or misuse prescription drugs? Yes ___ No ___ If yes, list:

Name of Drug	Frequency of Use

Counseling/Psychotherapy Information

Please describe the main concerns that prompted you to seek counseling/psychotherapy?

____

____

How have these concerns evolved or changed over time?

____

____

Please indicate what major stressors you have had in the last 12 months.

Serious Illness or Injury ___ Death of a Close Friend or Family Member ___ Major Illness in Family ___

Gain of New Family Member ___ Physical Move ___ Divorce/Separation ___ Job Change ___

Other ____

Have you ever had thoughts of suicide? Yes ___ No ___ Are you currently? Yes ___ No ___

Have you ever attempted suicide? Yes ___ No ___ If so, when? ________________________________

What would you like to be different in your life when you are done with therapy?

____

____

Have you ever received psychological or psychiatric counseling before? Yes ___ No ___
If so, please describe when, from whom, the purpose and results:

____

____

Have you ever been prescribed medicine for psychiatric or emotional problems? Yes __ No __
If so, please describe when, the prescribing clinician, what medication, for what, and the results:

____

____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes ___ No ___
If so, please describe when, where, for what reason, and the results:

____

____

Have you ever been in a drug or alcohol rehab program? Yes ___ No ___
If yes, how many times? ___ When? _________________ Inpatient ___ Outpatient ___ How long? ___

Outcome? ____

____

Is there anything else you think I should know before I begin working with you?

____

____

____

____

____

Thank you for your time in filling out this information.

I look forward to working with you.